

OREGON HEALTH FUND BOARD – Federal Laws Committee

February 28, 2008
10:00am (Digitally Recorded)

NW Health Foundation, Bamboo Room
221 NW 2nd Ave, Suite 300, Portland, OR

MEMBERS PRESENT: Frank Baumeister, M.D., Chair
Ellen Gradison, Vice Chair
Mike Bonetto
Chris Bouneff (by phone)
Michael Huntington, M.D.
Julie James
Mallen Kear, R.N.
Larry Mullins
Thomas Reardon, M.D.

MEMBERS EXCUSED: Nicola Pinson
Sharon Morris
Cheryle Kennedy

STAFF PRESENT: Susan Otter, Policy Analyst
Barney Speight, Executive Director, OHFB
Erin Fair, University of Oregon Law Student, OHFB Intern
Judy Morrow, Assistant

ABSENT STAFF:

ISSUES HEARD:

- Call to Order
- Approval of Agenda and Minutes from Jan 23 and Feb 14 Meetings
- Committee Discussion: Medicaid
- Medicare Beneficiary Advocates Panel: AARP
- Medicare Beneficiary Advocates Panel: Governor's Commission on Senior Services
- Medicare Beneficiary Advocates Panel
- Committee Discussion: Medicare
- Public Testimony

(Digitally Recorded)

Chair Baumeister I. Call to Order

- There is a quorum.

Chair Baumeister II. Approval of Agenda and January 23 and February 14 Meeting Minutes

Motion to approve the minutes as written is seconded. **Motion passed unanimously.**

Chair Baumeister III. Committee Discussion: Medicaid

Discussion concerning Committee's charge to evaluate how federal laws will impact healthcare reform in Oregon:

- Barney Speight, OHFB Director, related Board's timeline of draft recommendations by Late May to Mid or Late June, with public meetings to be held in September.
- Barney presented tentative framework of Board's reform that the Federal Laws Committee can work with:
 - Access expansion around Medicaid (some populations) and Family Health Insurance Assistance Program (FHIAP)
 - About 60% of uninsured are under 200% Federal Poverty Level (FPL)
 - 150,000 people are 300-400% of FPL
 - 40,000 people are 400% over FPL
 - Much can be done within Oregon's current waiver by adding State funds to expand coverage to the uninsured – OHP current waiver for up to 185% FPL, not being maximized, FHIAP limited by state funds
 - Individual mandate would lead to changes in voluntary market such as guaranteed issue. Would necessitate affordable insurance options.
 - Financing the reform package
 - Benefits package within reform
 - Waiver requests for federal match
- Discussion of how to prioritize federal Medicaid barriers heard so far. Much of what had been presented to the committee might not be top priority within the context of the Board's reform efforts. Committee should be strategic in report/recommendations – recognizing why federal policies exist, how we would change these and why these changes would be acceptable.
- Discussion of process of making recommendations to federal government:
 - Board's process – Oregon legislators would start by passing law to reform health care in Oregon. The legislation would need funding. This becomes the basis for requesting waivers or other federal changes.
 - CMS waiver process – DHS submits the waiver requests, CMS sets terms of accountability.
 - The report of the Federal Laws Committee will go to the Oregon Congressional delegation
 - Oregon Congressional delegation may want to put forth changes in law in Congress
 - Persuading CMS to make regulatory changes – would need a coalition of stakeholders
- Discussion of administrative rulemaking process and budget neutrality.
- One area of recommendations: ERISA law and the individual mandate
 - Federal regulation requires minimal reporting, states do not know the number of lives covered by self-insured plans
 - Law is vague resulting in problems with mandates and identifying acceptable funding strategies
 - What we know is due to the result of court cases
 - ERISA employers – approximately 700,000 employees in Oregon
- Committee discussed dividing recommendations into "buckets" and prioritizing each:
 - Waivers (Medicaid)
 - Statutory

- Regulatory
- Discussion of including citizenship documentation requirements as a federal barrier to expanding access to Medicaid, staff research will look for alternative approaches to propose
- How much of problem is federal, how much is state? State financing is a major barrier in and of itself – there is nothing the feds can do about that. Significant eligible but unenrolled population - partly an outreach issue, partly a state financing strategy issue
- We should be careful not to confine our recommendations to fit within the current system because the current system is unsustainable - we need to think “out of the box” and make new and creative recommendations – new funding, new outcome measures, etc.
- New and innovative accountability standards, i.e. – coding/encounter requirements for reimbursement versus reimbursing based on overall clinical outcomes. Also need to think about how to keep responsibility/accountability standards of some kind, but avoid perverse incentives.
- Difficulty in persuading federal government that Oregon is different – same in provider community – Oregon is more efficient.
- Think about how to initiate “conversation” with CMS - through Senate/other Members of Congressional delegation, through CMS leadership, DHS can talk to CMS as waivers/changes are being developed.
- Staff will bring information to the Committee on the following:
 - Expanding coverage to uninsured by state action, not prevented by federal barrier
 - Citizenship documentation requirements preventing eligible low-income Oregonians from accessing Medicaid
 - Flexibility with provider payment structure (paying for outcomes not based on encounter or claims data) within Medicaid waiver
 - Barriers related to federal mental health funds not under Medicaid and 16-bed limit for Medicaid payment of residential mental health care
 - Strategies to avoid losing special funding for Federally-Qualified Health Centers (FQHC) and Rural Health Clinics

Chair Baumeister IV. Medicare Beneficiary Advocates Panel: AARP

Rick Bennett, AARP Oregon Director of Government Relations provided testimony relating:

- 500,000 members:
 - 50-64 – one half of the members
 - 65 + - one half of the members
- Divided We Fail movement goals:
 - Health & Financial Security
 - Engage Citizens
 - Communication with elected officials
 - Finding solutions
- AARP Oregon supported SB 329

Dr. Chadron Cheriell, AARP Oregon Executive Council member (See written testimony, Presentation Materials 1)

- Access, Quality & Cost Control are key to health care reform

- Cost control, prevention and care coordination important for reform financing options
- Care coordination, prevention and eliminating inefficiencies in financing and delivery would be beneficial
- Overall rising health care costs is the real challenge. Medicare has benefited seniors financially, has low administrative costs, and has developed innovative cost-control strategies.
- Very little room to add health care costs to retired population
- Medicare offers portability, especially for seniors who reside in two different states over the course of the year. State-based programs would restrain portability.
- Part D prescription drug program – should raise asset limits for low-income subsidy, and should allow bulk negotiating/purchasing.

Kirsten Sloan, AARP (National-level) Legislative Health Team Leader

- Medicare should be reformed at the national level.
- Payment system rewards volume not quality
- Connection between FFS and managed care; states are penalized for efficiency
- Medicare Advantage (MA) discussed in US Congress - need greater balance between managed care and FFS: in 2006, \$7.1 billion more spent in MA programs than would have been spent under regular FFS
- Reimbursement rates
 - How can we tie Medicare rates with quality of care?
 - Recognizing regional differences with rates including unique situations like Oregon, where FFS costs are lower.
 - CHAMP Act – on House (MA)
- AARP supports:
 - Evidence-based research
 - Health Information Technology
 - Chronic Care Management
 - Pay for Performance and value based purchasing
- 80% of beneficiaries are in traditional Medicare (nationally) and about 80% of these have supplemental coverage
- Discussion concerning Oregon having highest penetration of MA (approx 38%). There are three types: HMOs, PPOs & PFFS. Most in Oregon MA are in managed care. What is AARP's position for states that have a high penetration for MA, what to do about expanding service?
 - MA enrollment nationally increased from 16 to 20% penetration; PFFS comprise greatest growth but also have the most problems – don't have coordinated care, no prescriptions, no requirement to stay within Traditional Medicare reimbursement rates; also offer low or no premiums – so they are attractive to beneficiaries.
 - Problems with marketing tactics; people think they are signing up for a supplement program, but are actually replacing Traditional Medicare. People think they can access any doctor or hospital, but they can't.
 - MA "brand" is being degraded by these bad players; how do we expand MA HMO coordinated care – higher reimbursements & benefits of coordinated care? Should offer genuine package that meets coordination needs & an affordable premium

- Medicare Modernization Act – income-related requirements for cost sharing of up to 50% Part B premiums. Still cost-shifting, doesn't address underlying systemic issues. Also, policy issue - asking a sub population to pay higher amount for health care – at some point they are going to get out of Medicare because these are the people who can afford to get out; they also tend to be healthier and they have paid more into the system over the course of their career.
 - Don't have data on those opting out of Part B due to cost.
- New report being published this month from Medicare Trustees regarding insolvency of Medicare program. Senior community has high rate of growth – 90% in OR from 2000-2025, and 140% in Bend area alone. Some areas of the country can't afford to wait for larger Medicare reform – that's why chronic care management and health information technology can be so important now.

Chair Baumeister V. Medicare Beneficiary Advocates Panel: Governor's Commission on Senior Services (See PowerPoint presentation, Presentation Materials 2)

Chuck Frazier, Commissioner, GCSS

- Per a Oregon Physician Workforce Survey (see Exhibit Material 9), nearly one-fourth of physicians have closed services to new Medicare beneficiaries – reimbursement cited as most important reason.
- GCSS is co-sponsoring a Medicare Access project – hope to develop a registry and demonstrate lack of access.
- Implications of lack of access: patients delay care, increase system costs. Lack of patient advocacy – less likelihood of individuals following good health practices. GCSS recommends:
 - Increasing reimbursement rate for primary care providers
 - Recognize the cost of doing business or consider a balance billing waiver
 - Consider "concierge care" programs by primary care providers (PCPs)
 - Encourage all Medicare/Medicaid patients to have a PCP
 - Clarify to PCPs that their role includes patient advocacy and education
- Ideas of patient-directed care and patients shopping for health care may not be realistic since patients don't know the costs of care, billing systems are slow and difficult to decipher, and patients' ability to catch errors is limited. Recommend:
 - Mandate clear and timely medical billing system
 - Require specific information on bills (service dates, charges)
 - Find ways to stop drawn-out adjudication process
- Poor use of Information Technology (IT) – recommend incentives to accelerate the application of IT to entire health care industry
- Need for Liability Reform – practice of 'defensive medicine' increases costs of health care. Recommend revisions of tort laws.
- Avoid duplication and waste – example, distribution of medical equipment and facilities across state is often not adequate to meet need. Recommend – creditable 'Certificate of Need' program to match need with resource availability

Robert Lawrence, Commissioner, GCSS

- "50+ initiative" to identify concerns in Lake Oswego. Lack of access to medical care for Medicare beneficiaries was a major concern. Robert

couldn't find a physician in Lake Oswego to take Medicare, ended up on Kaiser Medicare Advantage plan.

Peggie Beck, Commissioner, GCSS

- GCSS supports the reform efforts of the Board

Chair Baumeister VI. Medicare Beneficiary Advocates Panel

Steve Weiss, President, Oregon State Council for Retired Citizens (See Exhibit Materials 10 and 11)

- CMS provides continuity. Should be commended for:
 - Changes in benefits and drug formulary
 - Medicare Part D adding drug benefits
- Objections to Medicare Advantage plans – payments to MA plans doubled since 2003, enticing more plans, quality is worse, health outcomes are worse (from national MedPac article). These plans are not less expensive, some are not managing care – money could be better used elsewhere.
- Oppose integration of acute and long-term care into Board's reform plan. If long-term care is included in managed care then seniors end up in nursing homes that could otherwise have stayed at home.
- Recommends allowing a Medicare Advantage plan that is a publicly owned non-profit.

Janet Bowman, SHIBA & Medicare Outreach Coordinator, Multnomah County Aging & Disability Services (See handouts, Presentation Materials 3)

- Beneficiaries have a difficult time understanding the differences between Medicare Advantage and traditional Medicare. Difficult to choose between 93 Part D prescription drug plans in Multnomah County. Need to provide clear benefit information to seniors – this will be important for the Board's reform package as well. SHIBA helps folks select plans.
- Part D formula and copay changes – beneficiary may stop taking a drug if copay goes up or it is dropped from formulary. Counseling is needed.
- Misunderstanding about what skilled nursing care Medicare pays for – 100 days but only if patient is making progress, otherwise Medicare stops paying.
- Long term care in Oregon is a model for nation – don't put medical model on top of long term care system. Long term care is about how people live in the setting they choose.
- Discussion about how beneficiaries make choices between plans and access to SHIBA volunteers across Oregon. SHIBA does not track which doctors have openings for Medicare patients. Find idea of 'physician extenders' such as nurse practitioners interesting.

Chair Baumeister VII. Committee Discussion: Medicare

- Discussion of Medicare payment rate setting – history of Geographic Practice Cost Indices (GPCI) and Resource-Based Relative Value Scale (RBRVS), sustainable growth rate. Suppressing fees for physicians in Medicare has led to a crisis in access.
- Access is the greatest issue in Medicare

- Changes to Medicare not possible through state waivers – really law or regulatory changes. May be some demonstration/pilot programs available – staff will research this.

Chair Baumeister VIII. Public Testimony

Written testimony submitted by:

- **Betty Johnson (see Exhibit Materials 12 and 13)** email comments and submission of Newsday article: Who's looking out for Medicare's health?

Chair Baumeister IX. Adjournment

Meeting adjourned by Chair Baumeister.

Next meeting March 13, 2008.

Submitted By:
Paula Hird

Reviewed By:
Susan Otter

EXHIBIT MATERIALS

1. Agenda
2. Meeting Minutes from 01/23/08
3. Meeting Minutes from 02/14/08
4. Medicaid Themes heard by Committee
5. Sum of Presentations of 02/14/08
6. KFF Medicare Primer
7. OHPR report: Oregon Medicare Background
8. Commonwealth: Bending the Curve
9. Oregon Physician Workforce Survey
10. Myths of High Medical Costs (handout from Weiss)
11. Medicare Advantage Special Needs Plans (handout from Weiss)
12. Testimony: Betty Johnson email
13. Testimony: Betty Johnson submission of Newsday Medicare article
14. Rhonda Busek, LIPA testimony at Feb 14 meeting
15. Deborah Loy, Capital Dental Care testimony at Feb 14 meeting
16. Angela Kimball, NAMI presentation at Feb 14 meeting
17. Scott Ekblad, Office of Rural Health testimony at Feb 14 meeting
18. Pam Mariea-Nason, CareOregon testimony at Feb 14 meeting
19. DHS Citizenship Report
20. NEJM Article: Does Preventive Care Save Money?
21. NY Times Article: Governor's of Both Parties Oppose Medicaid Rules
22. CBPP article: Medicaid Weakening
23. "State of the States report," States Coverage Initiative, Jan 2008 (The report is available at: www.statecoverage.net/pdf/StateofStates2008.pdf.)

PRESENTATION MATERIALS

1. Dr. Chadron Cheriell's testimony, AARP
2. Governor's Commission on Senior Services presentation
3. Janet Bowman's handouts, Multnomah County Aging & Disability Services Division